



PATIENTS NAME: _____

DOB: _____

Notice of Privacy/No Show Policy Acknowledgement

I, _____, acknowledge that I have received from Illini Pediatrics, LLC a copy of their Privacy Notice and No Show Policy (rev 06/05/07). I understand it is my responsibility to read the notices and ask questions as necessary.

Patient Signature/Patient Representative

Date

Relationship to Patient

Witness

Date

**CONSENT FOR RELEASE OF INFORMATION TO DESIGNATED
FAMILY MEMBERS OR CAREGIVER.**

The Undersigned consent to Illini Pediatrics, LLC releasing his/her medical information to:

Name to Receive Info & Relationship to Patient

Name to Receive Info & Relationship to Patient

Name to Receive Info & Relationship to Patient

This consent remains in effect for a one (1) year period (as signed by the designee.) This form must be resigned at the year's expiration. This consent may be revoked at any time upon written request.

Signed _____

Date _____

Address _____

City/State _____

Phone _____

Signed _____

Date _____

Signed _____

Date _____

Signed _____

Date _____

Signed _____

Date _____